

- ☐ Initiate Waiver services
- ☐ Service Modification
 - ☐ Add a service
 - ☐ Increasing hours of service
 - ☐ Decreasing hours of service
- ☐ Change in SF (requires 2 ISARs)
- ☐ End CD service

MR Waiver Consumer-Directed Personal Assistance Individual Service Authorization Request

CSB _____

CSB provider # _____

Name:	Last	First	MI	Medicaid No:
Address:				
Street/Apt.			City, State	
Phone No.		Social Security No.		Patient Pay Amount: \$
Is this service designated to collect patient pay? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A SF agency, if applicable _____				
Services Facilitator:		Provider No:		Reassessment? <input type="checkbox"/> Yes <input type="checkbox"/> No

Will the individual be directing his or her own services? ☐ Yes ☐ No

If NO, name and relationship of responsible family member/caregiver: _____

SERVICE REQUESTED	WEEKLY/YEARLY HOURS		OMR USE ONLY
Fill in applicable dates:			
CD PA services start date may not precede: SF Start Date: _____			
SF End Date: _____			
S5126--CD PA Start Date: _____			
S5126--CD PA End Date: _____			
Total # of persons with disabilities in the residence _____	_____	x 52 =	Yearly total (1)
Enter periodic support hours per week if needed (Do not include in daily hours in weekly schedule below)	+ _____ Hours / week		
Enter total of periodic support hours + regular hours per week →	= _____ Hours / week	x 52 =	Yearly total (2)

Reason for this request: _____

Check the allowable activities included in the individual's ISP. Indicate the *total* number of hours per day of CD PA.

	Sun	Mon	Tue	Wed	Thur	Fri	Sat
Assistance with <input type="checkbox"/> activities of daily living (<i>Must be included to receive this service</i>) <input type="checkbox"/> monitoring health status & physical condition <input type="checkbox"/> self-medication and/or other medical needs <input type="checkbox"/> meal preparation and eating <input type="checkbox"/> housekeeping activities <input type="checkbox"/> participating in recreational activities <input type="checkbox"/> appointments or meetings <input type="checkbox"/> bowel/bladder programs, range of motion exercises, routine wound care (per MD's orders and RN oversight) <input type="checkbox"/> general support to assure safety <input type="checkbox"/> activities in the workplace (does not duplicate services at the worksite)							
Training for assistant <input type="checkbox"/> as requested by the individual or caregiver that relates to services described in the ISP							
Comments:							

Signature of Facilitator _____

Date _____

I agree that the above plan of services is appropriate to the identified needs of this individual. This service plan has been approved by the individual and included in the CSP maintained in the Case Manager's record.

CSB Rep/ Case Manager (print) _____

Phone No. _____

Fax No. _____

Signature _____

Date _____